Suicide and Self-Harm
Risks and Strategies in Long Term Care

“The Old Guitarist” by Picasso, 1903

Housekeeping
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  Education Specialist for Select Rehabilitation
- I have no financial or non-financial relationships related to the content of this course

Objectives
1. Understand the scope of the problem.
2. Identify risk factors in the medical record.
3. Identify warning signs in observable behavior.
5. Describe important actions in suicide prevention during the transition to residential communities.

6. Be able to discuss current suicide prevention strategies with family members and stakeholders.

7. Describe the changing perspectives of Baby Boomers.

8. Identify program objectives for improving emotional health.

Terms

- Suicide = death caused by self-directed injurious behavior with intent to die
- Attempt = non-fatal, self-directed potentially injurious behavior with intent to die. May not result in injury
- Ideation = thinking about, considering, or planning suicide
- Direct self-harm = e.g. cutting, ingesting with known harm to self
- Indirect self-harm = e.g. refusing food & hydration with known harm to self

the Suicide Scope

- Incidence rates
- Community settings
- Residential settings
- Racial/Cultural factors
- Generational/Coohort effect
Washington State by Means

- 627
- 354
- 192
- 46
- 63

Source: Washington State Department of Health

Cohort Effect

- 60% higher than previous generations
- Began a decade before the recession
- Generational paradigms: questioning purpose and meaning

Suicide Cluster or ‘Contagion’

- Several suicides or suicide attempts occur in a region or social group greater than would be expected by chance.
- Some literature report as few as 2 or 3 comprise a ‘cluster’
Celebrity Suicides
- Marilyn Monroe (1962)
  - age 36
  - depression
  - mental illness
  - ACEs
  - ↑ 12 % nationwide
- Kurt Cobain (1994)
  - age 27
  - clinical depression
  - drug and alcohol abuse
  - ↓ in 5, 10, 15 day counts
- Robin Williams (2014)
  - age 63
  - clinical depression
  - drug and alcohol abuse
  - new dx of Parkinson’s
  - ↑ 9.85 % across age groups

AI/AN Cultural cluster
- Universal Prevention
- Selective Prevention
- Indicated Prevention
- Critical transition points

Suicide Prevention Strategy
- Universal Prevention
- Selective Prevention
- Indicated Prevention
- Critical transition points
Universal Prevention

Community
- Reduce new cases in large populations
- Local, regional, national efforts
- Increased education & awareness
- Targets skills training

LTC / Residential
- All residents have access to programming that improves emotional health and coping
- Social networks are healthy between residents
- Access to lethal means is restricted
- All staff receives suicide prevention training appropriate to their level

Washington State Statistics
- 21st highest in the nation
- 17.5 people committed suicide per 100,000 population
- (14.5 people per 100,000 is the national average)
Selective Prevention

- General
  - Targets high-risk groups
  - Cumulative losses and life transitions
  - Increased vulnerability

- LTC / Residential
  - Activities to engage men
  - Residents with chronic pain and disease
  - Residents with persistent sleep disorders
  - residents showing warning signs

Indicated Prevention

- General
  - Imminent risk
  - Exhibit red flag behaviors
  - Mental illness indicators

- LTC / Residential
  - Imminent risk
  - Exhibit red flag behaviors
  - Mental illness indicators

Risk Factors vs. Warning Signs

- What to LOOK for
- What to LISTEN for
- What to FEEL for

“The Artist’s Father, Reading l’Evénement” by Paul Cézanne, 1866.
Building Awareness

Risk Factors
- Demographic
- History
- Medical Record

Warning Signs
- Red flags
- <80%
- Observable
  - Noticeable behavior change
  - Sudden ‘relief’
  - Intuitive

Knowable Risk Factors

- Demographic
  - Age
  - Veteran status
  - LGBTQ status
  - Cultural clusters

- Medical Record
  - Mental health dx
  - Alcohol abuse
  - Substance use
  - Chronic health dx
  - Pain

Ask-able Risk Factors

- Undocumented History
  - Past attempts
  - Family member attempt
  - ACEs

- Access
  - to mental health svcs
  - to lethal means

- Coping
  - Access to mental health
  - Prolonged stress
  - Situational stress
  - Critical transitions
  - Loss
Observable Warning Signs

Feelings
- Depression
- Anxiety
- Anger
- Persistent irritability
- Hopelessness
- Helplessness
- Shame/Humiliation

Behaviors
- Change in drug/alcohol use
- New med seeking
- Isolating self
- Giving things away
- Sudden joy
- Sleep changes
- Dietary changes
- Escalating self-harm
- Non-verbal cues

Asking About Suicide

- Myths
- Methods

“Self-portrait with Dr. Arrietta” by Francisco Goya, 1820

Asking about suicide does NOT put the idea in someone’s head.
How to Ask

“Are you thinking about suicide?”
“Do you have a plan to kill yourself?”

Direct Ask

“Are you thinking about suicide?”
“Do you have a plan to kill yourself?”

Avoidant Ask

“You aren’t thinking about killing yourself, are you?”

If YES

• Thank them for their honesty & courage
• Recommended ways to ask next questions:
  • Have you thought about how you would end your life?
  • Have you already considered how you access those means?
  • Are you thinking of when you might end your life?
• Warm hand-off to staff in charge
• Follow facility policy
Direct Response
“Who can help you limit your access to_____________?”

Avoidant Response
“Why would you do something like that? You have so much to live for.”

If NO
• Does your intuition agree?
• Do you detect discrepancies between this conversation and others you have had?

When people talk, listen completely. Don’t be thinking about what you’re going to say. Most people never listen. Nor do they observe.
-Ernest Hemingway
“Who hasn’t thought about it?”

- Distinguish between casual talk vs. intentional harm
- Casual ‘death’ talk appears to be an age-appropriate norm
- Ethical questions vs. practical considerations
- Listen for specific intentionality
- If concerned, ask directly, without euphemism

Long Term Care

- Organizational strategies
- Transition crisis
- Family education
- Packet materials

“Sorrowing Old Man”, by V. Van Gogh, 1890 – 2 mo. before his death.

ALL Staff, Every Level

- Identify and respond to warning signs
- Can demonstrate what to do when risk is detected
- Recognize alcohol abuse
- Recognize medication misuse
- Promote protective factors
Designated Staff Education

- Practice suicide screening interviews
- Know warning signs of elevated risk vs. imminent danger
- Activate appropriate actions when elevated risk is detected
- Understand facility policies
- Review training at appropriate intervals

Residential Care Stories

Rev. Milton P. Andrews Jr., a former Seattle pastor

Lethal Means

<table>
<thead>
<tr>
<th>Community</th>
<th>LTC / Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearms (more likely ♂)</td>
<td>Jumps/falls (more likely)</td>
</tr>
<tr>
<td>Medication (more likely ♀)</td>
<td>Firearms (less likely)</td>
</tr>
<tr>
<td></td>
<td>Medication (equally likely)</td>
</tr>
</tbody>
</table>
Lethal means

- A resident's daughter and her husband were visiting. They left the room briefly. When they returned, she was gone. The daughter looked out an open window and saw her mother on the ground below.

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Risk vs. Protection in Elderly

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Optimistic</td>
</tr>
<tr>
<td>Number of medications</td>
<td>Internal locus of control</td>
</tr>
<tr>
<td>Loss of a spouse within 1 year</td>
<td>Sense of belonging</td>
</tr>
<tr>
<td>Perceiving themselves as a burden</td>
<td>Satisfaction with life</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>Emotional health programming</td>
</tr>
<tr>
<td>- Alzheimer's disease</td>
<td></td>
</tr>
<tr>
<td>- Huntington's disease</td>
<td></td>
</tr>
<tr>
<td>- Chronic sleep disturbances</td>
<td></td>
</tr>
<tr>
<td>- Alcohol dependence or 'misuse'</td>
<td></td>
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<tr>
<td>(35% of elder males)</td>
<td></td>
</tr>
</tbody>
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PBS News Hour, April 9, 2019
Elevated Risk of New Residents

- Highest at the point of transition from home
- Once relocated, ↑ risk within the first 7-8 months
- 12% of newly relocated LTC residents had suicidal thoughts
- 6% at the time of admission
- 2.3% at two weeks following
- 2.9 at two months following

Facility Policies re. Risk

- Policies need to limit lethal means, but not be activity limiting
- More intense facility security was positively associated with depressive symptoms and suicidal behavior. (Low et al., 2004)
- Elevation of watch status over time is an important freedom and resident right.
- Increased level of scrutiny.

Federal Consequences

- An 81-year-old architect fatally shot himself while his roommate was nearby in their shared room in a Massachusetts nursing home in 2016. The facility was fined $66,705.
- A 95-year-old World War II pilot hanged himself in an Ohio nursing home in 2016, six months after a previous attempt in the same location. The facility was fined $42,575.
- An 82-year-old former aircraft mechanic, who had a history of suicidal ideation, suffocated himself with a plastic bag in a Connecticut nursing home in 2015. The facility was fined $1,020.
The Four D’s of Suicide Risk

- Depression
- Disease
- Deadly means
- Disconnectedness

Improving Emotional Health

May 1, 1869 UK news clipping

Cultivating a ‘Lively View of Things’

- Wellness programs
  - physical activity
  - mindfulness
  - sleep hygiene
- Activity programs
  - engagement
  - participation
- Resilience Training
  - What is it and how do I implement it?
Resilience Program Hypothesis

• “Since having reasons for living and leading a meaningful life are incompatible with suicide, it could be possible that the realization of important personal goals might enhance hope and meaning in life, two protective factors against suicide.”

• “...the...program would be effective in increasing psychological well-being and decreasing levels of depression in the participants with suicidal ideations.”

  (Lapierre et al., p.17)

Resilience Program Design

• Week 1: Meeting group members, self-introduction
• Week 2: Discussing the (transition) experience.
• Week 3: Inventory of personal goals, intentions, aspirations, and projects. Identification of irrational beliefs about goals.
• Week 4: Selection of goals that have a high priority and evaluation of each of them according to different characteristics (effort, stress, enjoyment, difficulty, resources, conflict, control, probability of attainment).
• Week 5: Description of the goal in concrete and precise terms as a target-behavior. Selection of one goal and personal commitment to its realization.
• Week 6-7: Planning of goal-related action (where, when, how), anticipating obstacles and identifying strategies to face them, identifying personal and social resources. Planning should be reevaluated regularly. Suggestions from the group are important at this time.
• Week 8-10: Execution of the plan, persistence toward the goal, facing difficulties with the emotional support of the group. Revision of goal-planning could be necessary and even questioning the priority of the goal.
• Week 11: Evaluation of the outcome and progress in reaching the goal. Evaluation of the learning process.
When she developed a urinary tract infection, her condition worsened. Anxious and depressed, she told an aide she wanted to hurt herself with a knife. She was referred for psychological services and improved. Weeks later, after a transfer to a new unit, she was found in her room with the cord of a call bell around her neck.

After a brief hospitalization, she returned to the nursing home and was surrounded by increased care: a referral to a psychiatrist, extra oversight by aides and social workers, regular calls from her brother. During weekly counseling sessions, the woman now reports she feels better.

“She’s 99 now — and she’s looking toward 100.”

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**Transitioning Safely**

- Family preparation
- Warning signs checklist tool
- Managing lethal means

*Mother* by Gely Korchev, 1964-67

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**Family Education**

- Be direct
  - “I’d like to talk now about the uncomfortable topic of suicide”
- Frame the topic in terms of statistics and statewide efforts
  - “We know that suicide attempts increase after age 75 and again after age 85. Washington state is leading the nation in suicide prevention. Towards that effort, we’d like to make sure that your loved one transitions safely. Here’s a checklist to review as you’re getting ready for the move, and if something concerning comes up, please discuss it with us, so we can support your loved one once they arrive.”
Transition Checklist:
Feelings/Mood

- Do you see or hear a change in level of depression or anxiety?
- Do you see or hear signs of new anger or irritability greater than usual?
- Do you see or hear statements of hopelessness or helplessness?
- Do you see or hear signs of shame or humiliation?
Transition Checklist: Behaviors

☐ Are you aware of new social isolation?

☐ Have you observed or are you aware of any change in drug or alcohol use?

☐ Have you observed or are you aware of giving away prized possessions, beyond expected ‘downsizing.’

☐ Have you observed or are you aware of recent loss of interest or less engagement in favorite activities?

☐ Have you observed or are you aware of any changes in sleep?

☐ Are you aware of any new and unexpected weight loss or weight gain?

☐ Have you observed or are you aware of any new change in eating pattern?

☐ Have you observed or are you aware of any incident of self-harm?

Transitional Checklist: Lethal Means

☐ Work with the resident to lock up, transfer ownership of, or take possession of firearms before the planned transition.

☐ Work with the resident to contact local agencies for hazardous materials collection events/sites and discard toxic chemicals (pesticides, poisons, etc.) from the home, under sinks, laundry areas, garage, and any outbuildings.

☐ Work with the resident to secure or limit access to belts, ropes, cords, hoses and the like.

☐ Work with the resident to secure car keys or limit unattended driving around the transition time.

Transition Checklist: Medications

☐ Have you observed or been asked to stockpile medications for any reason?

☐ Have you been asked to get larger pill counts or bigger bottles of medications?

☐ Does the home have a lock box for medication surplus?

☐ Reduce available quantities of over the counter medications.
Why the Resident Interview?

- Interview process is a Major Component of MDS 3.0
- Gives the resident a voice
- Gain resident self-reported information and perspective
- Important aspect of the entire care planning process
- Proven method of data gathering for specific topics
- All residents capable of any communication should be asked to provide information regarding what they consider to be the most important facets of their lives

Why a ‘scripted’ Interview?

- An interviewing technique that requires following a ‘script’
- Questions must be asked exactly as written
- The wording has been proven to be effective with an elder population
- Provides a standardized approach that delivers more accurate results

Pre-Interview
MDS B0700: Makes Self Understood

Progress to interview if this item = 0, 1, or 2

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MDS B0800: Ability to Understand Others

Progress to interview if this item = 0, 1, or 2

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Setting up the Interview

- Private setting
- Ensure resident can hear
- Sit facing the resident, minimize glare
- Give an introduction
- Assure them that you ask the same questions of everyone.
- Explain purpose = helps design a custom care plan
- Accept refusals, move on to the next

72
Timing the PHQ-9 Interview

- Avoid interviewing during the initial assessment
- First treatment session, suggested
- All MDS sections (B, C, D & K) – 30 min.
- "Is this a good time to complete our interview?"

Resident Interview

- Read the item as it is written
- Do not provide definitions
- Meaning must be based on resident's interpretation
- Each question must be asked in sequence, NO variation
- Enter code 9 for any nonsensical response
- For a "yes" response, determine frequency

Column 1: Symptom Presence

- Code 0, No: If resident indicates symptoms listed are not present enter 0. Enter 0 in column 2 as well
- Code 1, Yes: If resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency
- Code 9, no response: If the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.
Column 2: Symptom Frequency

- Code 0, never or 1 day: If the resident indicates that he or she never or has only experienced the symptom on 1 day
- Code 1, 2-6 days (several days): If the resident indicates that he or she has experienced the symptom for 2-6 days
- Code 2, 7-11 days (half or more of the days): If the resident indicates that he or she has experienced the symptom for 7-11 days
- Code 3, 12-14 days (nearly every day): If the resident indicates that he or she has experienced the symptom for 12-14 days

Coding Guidance

- If the resident uses his or her own words, briefly explore
- Select one frequency response per item
- If difficulty selecting between two frequencies, code the higher frequency
- If different frequencies for different parts of a single item, select the highest frequency
Item D0200I: Suicidal Ideation

- Ask openly, directly, and without hesitation
- Ask exactly as worded
- Asking the question does not give the idea
- Notify the responsible clinician
- Follow facility protocol

Total Severity Score

- Do not add the score during the interview
- Maximum score is 27
- Interview is successful if resident answered frequency responses of at least 7/9 items
- If symptom frequency is blank for 3+ items, the interview is not complete
- Total score is a two-digit number

<table>
<thead>
<tr>
<th>Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe</td>
</tr>
<tr>
<td></td>
<td>depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>
The Friendship Line
1-800-971-0016

References